

3844

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>p. COUNTY <u>Caroline</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  | d. STREET ADDRESS  |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>AP. T. HUR</u> First <u>ELWOOD</u> Middle <u>ANTHONY</u> Last  |  | 4. DATE OF DEATH<br>Month <u>APR.</u> Day <u>7</u> Year <u>1956</u>  |   |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 20, 1912</u>                            |
| 9. AGE (In years last birthday) <u>43</u> yrs.   |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>Arthur Anthony</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Kella Smith</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <u>17</u> 17. INFORMANT <u>Arthur L. Anthony</u> Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>416X Coronary Thrombosis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Cardiovascular Dis.</u><br>DUE TO<br>(c) |  |  | INTERVAL BETWEEN ONSET AND DEATH                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                            |
| 21. I certify that I attended the deceased from <u>Jan. 10, 1953</u> to <u>Apr. 7, 1956</u> , that I last saw the deceased alive on <u>April 6, 1956</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.   |  |  |   |
| ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D.   |  | ADDRESS (Street, city or town, state) <u>Greensboro, Maryland</u> DATE SIGNED <u>4/9/56</u>  |   |
| PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer</u>   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF <u>Apr. 10, 1956</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Piney</u>  | 22d. LOCATION (City, town, or county) (State) <u>Denton Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. H. Moore</u> ADDRESS <u>2nd Denton, Md.</u>  |  | 24a. REC'D BY REGISTRAR DATE <u>4/10/56</u>  | 24b. REGISTRAR'S SIGNATURE <u>Wm. D. George</u>                 |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 18 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3845

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03824

Reg. Dist. No. 61

1. PLACE OF DEATH: *Carlisle*  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *4 3 yrs.*  
 Hospital, institution, or street address where death occurred: *Main St.*  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....*Maryland* County.....*Carlisle*  
 City or town.....*Hickman*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....*Main Street*  
 (If rural, give LOCATION)  
 2(a) If veteran, name war.....

3. (a) FULL NAME *Bertha Brown Breeding* 3. (b) Social Security Number *219-07-6194*

4. Sex *Female* 5. Color or race, *White* 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife *Hilli H. Breeding*

7. Birth date of deceased (mo., day, yr.) *July-13-1895* 6. (c) If alive, give age..... years

8. AGE: Years *60* Months *9* Days *17* If less than one day..... hrs. .... min.

9. Birthplace *Bridgetown, Sussex Co., Delaware*  
 (Town, County, and state)

10. Usual occupation *Housewife*

11. Industry or business

12. Name *Jonathan Brown*

13. Birthplace *Rosie Adams*

14. Maiden name *Hilli H. Breeding*

15. Birthplace *Denton - Md. - (R.I.)*

16. Informant *Burial* Address *Denton - Md. - (R.I.)*

17. (Burial, cremation, or removal, which?) *Burial* Date thereof *May 3-1956*  
 (month) (day) (year)

Cemetery or crematorium *Consent*

Location *Consent - Maryland*

18. Funeral director *(Mrs.) Reta Knight Boyer*  
 Address *Livingston, Delaware*

19. *May 1* 19 *56* *L. MacPiggin*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *April, 30, 1956* at *8 a. m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Feb 17* 19 *54* to *Apr 30* 19 *56*  
 and that I last saw him/her alive on *Apr 29* 19 *56*

Immediate cause of death *CACHEXIA* DURATION *4 WKS*

Due to *METASTATIC MALIGNANCY* 24RS

Due to *GEST ADENOCARCINOMA RIGHT OVARY* 24RS

Other conditions *175X*

(Include pregnancy within 8 months of death)

Major findings of operations *ABOLE FEB 1956*

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?  
 23. SIGNATURE *Robert H. Knight* M. D. or other  
 Address *Quindlen Rd* Date signed *5-1-56*

Dr. Robert Haight,  
Greenboro, Ind.

BUREAU V. S.

MAY 3 1956

RECEIVED

3846

## CERTIFICATE OF DEATH

03825

Reg. Dist. No.

62

|  |                           |  |                                      |
|--|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Caroline</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>              |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>   |                           | c. LENGTH OF STAY IN lb <u>15 yrs</u>  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                           | d. STREET ADDRESS  |                                      |
| 3. NAME OF DECEASED (Type or print) <u>LYNFORD</u> <u>HENRY</u> <u>CORDREY</u>   |                           | 4. DATE OF DEATH <u>APR.</u> <u>13</u> , 19 <u>56</u>  |                                      |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Apr. 4, 1901</u> |
| 9. AGE (In years last birthday) <u>55</u> yrs.   |                           | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber mill</u>   |                                      |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                                      |
| 13. FATHER'S NAME <u>John H. Cordrey</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Effie M. Evans</u>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                           | 16. SOCIAL SECURITY NO. <u></u>  |                                      |
| 17. INFORMANT <u>Eura. (Betty Cordrey)</u>   |                           | Address <u>Denton, Md</u>  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary thrombosis</u><br><u>910.3</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombophlebitis leg</u><br>DUE TO (c) <u>Compminuted fractures of the leg.</u> |                           |  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Partly severed</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>25 min.</u><br><u>6 weeks.</u>  |                           |  |                                      |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                           |  |                                      |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lumber tumbled down and across his legs.</u>             |                                      |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>3-1-56</u>  |                           | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <u>Lumber Mill</u>                             |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Denton</u>   |                           | 20f. (City or town) (County) (State) <u>Caroline Md</u>  |                                      |
| 21. I certify that I attended the deceased from <u>March 1, 1956</u> , to <u>April 13, 1956</u> , that I last saw the deceased alive on <u>April 13, 1956</u> , and that death occurred at <u>4:40 A.M.</u> from the causes and on the date stated above.  |                           |  |                                      |
| ACTUAL SIGNATURE <u>E Paul Knotts</u>  |                           | ADDRESS (Street, city or town, state) <u>Denton Md</u>   |                                      |
| PHYSICIAN'S NAME (Type) <u>E Paul Knotts</u>   |                           | DATE SIGNED <u>Denton Md</u>   |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                           | 22b. DATE THEREOF <u>Apr 15, 1956</u>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>   |                           | 22d. LOCATION (City, town or county) (State) <u>Denton Md</u>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Fugle</u>   |                           | ADDRESS <u>Denton</u>  |                                      |
| 24a. REC'D BY REGISTRAR <u>George</u>  |                           | 24b. REGISTRAR'S SIGNATURE <u>George</u>   |                                      |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

BUREAU V. S.

APR 18 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

63

3847

|  |                                  |   |  |   |  |   |  |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Caroline</u> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Preston</u>   |                                  |   |  | c. LENGTH OF STAY IN 1b<br><u>Life</u>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Noble Avenue</u>  |                                  |   |  | d. STREET ADDRESS<br><u>Noble Avenue</u>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Jacob</u> Middle <u>Lee</u> Last <u>Covey</u>  |                                  |   |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>5</u> Year <u>1956</u>  |  |   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>February 28, 1883</u> | 9. AGE (In years last birthday) yrs.<br><u>73</u>   | IF UNDER 1 YEAR<br>Months <u>8</u> Days <u>15</u> Hours <u>00</u> Min. <u>00</u> | IF UNDER 24 HRS.<br>Hours <u>00</u> Min. <u>00</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Merchant</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Hardware Store</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Caroline Co., Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Joshua F. Covey</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Amanda Smith</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>220-28-2041</u>   |  | 17. INFORMANT<br><u>Mrs. Effie M. Covey, Preston, Maryland</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized Metastasis of Lymphatic</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lymph. sarcoma (Mediastinum)</u><br>DUE TO<br>(c) _____ |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>8 mos</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>  |                                  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>3/22</u> , 19 <u>55</u> , to <u>4/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/14</u> , 19 <u>56</u> , and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above.  |                                  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><u>Harold B. Plummer</u> M.D.  |                                  |   |  | DATE SIGNED<br><u>Preston, Maryland 4/7/56</u>  |  |   |  |
| PHYSICIAN'S NAME (Type)<br><u>Harold B. Plummer, M.D.</u>  |                                  |   |  | <u>Preston, Maryland</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>April 8, 1956</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Hill Crest Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Federalburg, Maryland</u>                     |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>J.J. Frampton and Son, Federalburg, Md.</u>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br><u>4-7-56</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Harold B. Plummer</u>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. 1

APR 10 1956

RECEIVED



3848

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Caroline</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Greensboro</u>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Greensboro</u>   |  |   |  |
| c. LENGTH OF STAY IN 1b<br><u>37 Yrs.</u>  |  |   |  | d. STREET ADDRESS<br><u>None</u>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>None</u>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Alvah Howard Dabson</u>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>4 7 1956</u>   |  |   |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>1/30/1889</u>                                    |  |
| 9. AGE (In years last birthday)<br><u>67</u> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Audit Clerk F.H.A. Retired</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>            |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><u>Thomas Dabson</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Lidia A. Carter</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)<br><u>None</u>                          |  | 17. INFORMANT<br>Address<br><u>Margaret Dabson Greensboro, Md.</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u><br><u>502.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Bronchitis</u><br>DUE TO (c) <u>Pulmonary Emphysema</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH _____ |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                    |  |
| 21. I certify that I attended the deceased from <u>June 15</u> , 19 <u>54</u> , to <u>April 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 6</u> , 19 <u>56</u> , and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>4/10/56</u>  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D.   |  |   |  |   |  |   |  |
| PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>   |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>4/11/56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Greensboro</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Greensboro, Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>J. E. Bouclair</u> ADDRESS <u>Greensboro, Md.</u>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>Apr. 11 - 1956</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>L. M. Piggins</u>                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

3455

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. S.

APR 18 1956

RECEIVED

3849

CERTIFICATE OF DEATH

Reg. Dist. No. 64

|  |                                  |   |  |   |   |
|--|----------------------------------|---|--|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Caroline</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>9 Yrs.</u>  |  | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Caroline</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                  | d. STREET ADDRESS<br><u>Vernon Avenue</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Theela</u> Middle <u>Gallagher</u> Last <u>Dean</u>  |                                  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>25</u> Year <u>1956</u>   |  |   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 2, 1980</u> | 9. AGE (In years last birthday) <u>76</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housework</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Caroline County</u>   |   |
| 13. FATHER'S NAME<br><u>Thomas Gallagher</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  | 17. INFORMANT<br><u>J. Harold Dean,</u> Address <u>Federalsburg, Md.</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Nephritis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Accident Hypertension</u><br>DUE TO (c) <u>1 Yr.</u> |                                  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 months</u>                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>56</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Federalsburg, Md.</u>  |   |
| 20f. (City or town)<br><u>Federalsburg</u>   |                                  | 20g. (County)<br><u>Caroline</u>  |  | 20h. (State)<br><u>Md.</u>  |   |
| 21. I certify that I attended the deceased from <u>4/11/56</u> to <u>4/25/56</u> , that I last saw the deceased alive on <u>4/25/56</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.  |                                  |   |  |   |   |
| ACTUAL SIGNATURE <u>Frank M. Anderson</u> M.D.   |                                  | DATE SIGNED <u>4/25/56</u>  |  |   |   |
| PHYSICIAN'S NAME (Type)<br><u>Frank M. Anderson</u>  |                                  | <u>Federalsburg, Maryland</u>   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>April 23, 1956</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Hill Crest Cemetery</u>  |   |
| 22d. LOCATION (City, town, or county)<br><u>Federalsburg</u>   |                                  | 22e. (State)<br><u>Md.</u>  |  |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>J. J. Frampton and Son</u>  |                                  | ADDRESS<br><u>Federalsburg, Md.</u>   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>4/28/56</u>  |   |
|  |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Margaret H. Frampton</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate must be signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 3 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3850

## CERTIFICATE OF DEATH

Reg. Dist. No. 03822

|  |                           |  |                                       |   |  |  |  |
|--|---------------------------|--|---------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Caroline</u> MARYLAND  |                           |  |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hedgeley</u>   |                           | c. LENGTH OF STAY IN 1b <u>50 yrs</u>  |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hedgeley</u>  |  | d. STREET ADDRESS  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                           |  |                                       | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>FRANK</u> First <u>MOGBY</u> Middle <u>HOAGERS</u> Last   |                           |  |                                       | 4. DATE OF DEATH Month <u>APR</u> Day <u>19</u> Year <u>1956</u>  |  |  |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       | 8. DATE OF BIRTH <u>JUNE 27, 1873</u> |   | 9. AGE (In years last birthday) <u>82</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR, MGR.</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>CANNING</u>   |                                       | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                          |  |
| 13. FATHER'S NAME <u>Robert C. Hoaggers</u>  |                           |  |                                       | 14. MOTHER'S MAIDEN NAME <u>Elizabeth J. Murphy</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                           | 16. SOCIAL SECURITY NO.  |                                       | 17. INFORMANT <u>Sam Frank Hoaggers, Hedgeley</u>   |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Failure</u><br>DUE TO <u>Generalized Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 days</u><br>DUE TO (c) <u>years</u> |                           |  |                                       | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, Hypertrophic</u>  |                           |  |                                       |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           |  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <u>19</u>  |                           | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                             |  |
| 21. I certify that I attended the deceased from <u>April 18, 1956</u> to <u>April 19, 1956</u> , that I last saw the deceased alive on <u>April 18, 1956</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.   |                           |  |                                       |   |  |  |  |
| ACTUAL SIGNATURE <u>Charles H. W. W. N. COTT</u>   |                           |  |                                       | DATE SIGNED <u>April 24, 1956</u>   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>CHARLES H. W. W. N. COTT</u>  |                           |  |                                       |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                           | 22b. DATE THEREOF <u>Apr. 22, 1956</u>   |                                       | 22c. NAME OF CEMETERY OR CREMATORY <u>Genton</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Genton, Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. W. W. N. COTT</u>  |                           |  |                                       | ADDRESS <u>Genton</u>   |  | 24a. REC'D BY REGISTRAR DATE <u>4/24/56</u>                      |  |
|  |                           |  |                                       | 24b. REGISTRAR'S SIGNATURE <u>Mary C. Bird</u>  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

APR 26 1956

BUREAU Y. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3851

## CERTIFICATE OF DEATH

03830  
103

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Caroline</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Maryland</b>  |  | c. LENGTH OF STAY IN 1b<br><b>25 Yrs.</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>None</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>Dr. Robert Glen Miller</b>   |  | 4. DATE OF DEATH Month Day Year<br><b>4 27 1956</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/22/1885</b>  |
| 9. AGE (In years last birthday)<br><b>70</b> yrs.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Medical Doctor Retired</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Iowa</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>James Miller</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ella Miller</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, (unknown))<br><b>None</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Maria Miller</b>   |  | Address<br><b>Rural Maryland, D.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden Hemorrhage</b><br>DUE TO <b>Coronary Arteriosclerosis Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b><br>(c) <b>Coronary Arteriosclerosis</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>16 hrs</b>                            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>April 20</b> , 1956, to <b>April 27</b> , 1956, that I last saw the deceased alive on <b>April 27</b> , 1956, and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above.   |  |  |  |
| ACTUAL SIGNATURE <b>Chas. H. Stonesifer</b> M.D.   |  | ADDRESS (Street, city or town, state) <b>Greensboro, Maryland</b>  |  |
| DATE SIGNED <b>4/28/56</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Chas. H. Stonesifer, M.D.</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>4/30/56</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Greensboro</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Greensboro, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. E. Boulaie</b>   |  | ADDRESS<br><b>Greensboro, Md.</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>April 30</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Albert Smith</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after the death. The low requires that the death certificate be executed within 24 hours after the death. The low requires that the death certificate be executed within 24 hours after the death.

BUREAU V. S.

MAY 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VS A15 (4)  
15M 9/55

|  |                                    |   |                               |
|--|------------------------------------|---|-------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Caroline</b> MARYLAND  |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>                 |                               |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Federalsburg</b>  |                                    | c. LENGTH OF STAY IN 1b<br><b>Life</b>  |                               |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                    | d. STREET ADDRESS   |                               |
| 3. NAME OF DECEASED (Type or print)<br>First <b>James</b> Middle <b>Henry</b> Last <b>Prattis</b>  |                                    | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>24</b> Year <b>1956</b>   |                               |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH              |
| 9. AGE (In years last birthday)<br><b>85</b> yrs.  |                                    | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Day Laborer</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Town of Federalsburg</b>  |                               |
| 11. BIRTHPLACE (State or foreign country)<br><b>Federalsburg, Md.</b>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                               |
| 13. FATHER'S NAME<br><b>Henry Prattis</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Anne Chase</b>  |                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                    | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |                               |
| 17. INFORMANT<br><b>Bertha E. Prattis, Federalsburg, Maryland</b>  |                                    | Address   |                               |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c) |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs</b>  |                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                    | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                               |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>  |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                               |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)  |                               |
| 21. I certify that I attended the deceased from <b>1/1</b> , <b>1956</b> , to <b>4/24</b> , <b>1956</b> , that I last saw the deceased alive on <b>4/24</b> , <b>1956</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above.                      |                                    | DATE SIGNED <b>4/30/56</b>  |                               |
| ACTUAL SIGNATURE <b>Frank M. Anderson, M.D.</b>  |                                    | ADDRESS (Street, city or town, state) <b>Federalsburg, Md.</b>  |                               |
| PHYSICIAN'S NAME (Type) <b>Frank M. Anderson, M.D.</b>   |                                    | FEDERAL HILL CEMETERY   |                               |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                    | 22b. DATE THEREOF<br><b>April 28, 1956</b>  |                               |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Federal Hill Cemetery</b>   |                                    | 22d. LOCATION (City, town, or county) (State)<br><b>Federalsburg, Maryland</b>  |                               |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J.J. Frampton and Son, Federalsburg, Maryland</b>   |                                    | 24a. REC'D BY REGISTRAR<br><b>4/28/56</b>   |                               |
| 24b. REGISTRAR'S SIGNATURE<br><b>Margaret H. Frampton</b>  |                                    |   |                               |

Reg. Dist. No. 64

03832

BUREAU V. S.

MAY 8 1936

RECEIVED



3853

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Caroline</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission)<br>b. COUNTY <u>Caroline</u>                                       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  | d. STREET ADDRESS <u>Main St.</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Eppie W. Kyle</u>  |  | 4. DATE OF DEATH <u>4/28/56</u>  |  |
| 5. SEX <u>Female</u>  | 6. COLOR OF RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/23/1890</u>  |
| 9. AGE (In years last birthday) <u>65</u> yrs.  |  | IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>William B. Webster</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Gordon</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <u>Michael Kyle, Preston, Md.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Cardiac Compensation</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u><br>DUE TO<br>(c) |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 1/2 yrs</u><br><u>8 yrs</u>                           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson Disease</u> <u>8 yrs.</u>  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>11/2</u> 19 <u>55</u> , to <u>4/28</u> 19 <u>56</u> , that I last saw the deceased alive on <u>4/28</u> 19 <u>56</u> , and that death occurred at <u>2:20 P</u> M, from the causes and on the date stated above.   |  |  |  |
| ADDRESS (Street, city or town, state) <u>Preston, Maryland</u>  |  |  |  |
| ACTUAL SIGNATURE <u>Harold B. Plummer</u> M.D.  |  | DATE <u>4/30/56</u>  |  |
| PHYSICIAN'S NAME (Type) <u>Harold B. Plummer</u>  |  | PRESTON, MARYLAND  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF  | 22c. NAME OF CEMETERY OR CREMATORY   | 22d. LOCATION (City, town, or county) (State)  |
| <u>Burial</u>   | <u>4/1/56</u>  | <u>East New Market</u>   | <u>East New Market, Md</u>   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth S. Halloway</u>  |  | 24a. REC'D BY REGISTRAR <u>DATE 4-30-56</u>  |  |
| ADDRESS <u>East New Market</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Cornelia L. Plummer</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate may be retained by the funeral director. The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the funeral director.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S.

1956

RECEIVED

77

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3854

## CERTIFICATE OF DEATH

03834

Reg. Dist. No. 62

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Caroline</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>              |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  | d. STREET ADDRESS  |  |
| 3. NAME OF DECEASED (Type or print) <u>CHARLOTTE Middle SATTERFIELD</u>   |  | 4. DATE OF DEATH Month <u>Apr.</u> Day <u>22</u> Year <u>1956</u>  |  |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Apr. 27, 1866</u>                                |
| 9. AGE (In years last birthday) <u>89</u> yrs.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Clark</u>  |  | 14. MOTHER'S MAIDEN NAME   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <u>George Satterfield Denton, head.</u>   |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arterio sclerosis</u><br>DUE TO (c) |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>12 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                 |
| 21. I certify that I attended the deceased from <u>March 18</u> , 19 <u>56</u> , to <u>April 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 22</u> , 19 <u>56</u> , and that death occurred at <u>8:13 a.m.</u> from the causes and on the date stated above.   |  |  |  |
| ACTUAL SIGNATURE <u>E. Paul Knotts</u> M.D.   |  | ADDRESS (Street, city or town, state) <u>Denton Md</u>   |  |
| PHYSICIAN'S NAME (Type) <u>E. Paul Knotts</u>   |  | DATE SIGNED  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF <u>Apr 26, 1956</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Greenbloom</u>   | 22d. LOCATION (City, town, or county) (State) <u>Greenbloom Ind</u>  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jo Kingd Norton Denton</u>  |  | 24a. REC'D BY REGISTRAR  | 24b. REGISTRAR'S SIGNATURE <u>Wm D O George</u>                      |
|   |  | DATE <u>4-26-56</u>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956

APR

RECEIVED

3856

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Caroline</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Choptank</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>14yrs.</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>none</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Choptank, Preston, Md.</b>   |   |
| d. STREET ADDRESS  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Andasie</b> Middle <b>T.</b> Last <b>Williamson</b>  |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>30</b> Year <b>1956</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 3, 1884</b>  |
| 9. AGE (In years lost birthday) <b>72</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>housewife</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |
| 13. FATHER'S NAME<br><b>James Rodney</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Andasie Birch</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service)<br><b>219-05-6841</b>   |   |
| 17. INFORMANT<br><b>C. Edward Williamsen</b>   |                                  | Address<br><b>Choptank, Md.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO <b>Coronary Artery Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Obesity</b><br>(c) |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>30 minutes</b><br><b>5 years</b>                           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. g. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>1954</b> to <b>April 30, 1956</b> , that I last saw the deceased alive on <b>April 30, 1956</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.   |                                  |   |   |
| ACTUAL SIGNATURE<br><b>W.C. Harrison</b>   |                                  | DATE SIGNED<br><b>5/1/56</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>W.C. Harrison M.D.</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>Hurlock, Md.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>May 2, 1956</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Federalsburg, Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. Harvey Williamson</b>  |                                  | ADDRESS<br><b>Federalsburg, Md.</b>   |   |
| 24a. REC'D BY REGISTRAR<br><b>5-4-56</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Cornelia B. Plummer</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

1956

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

CITY OF BIRTH

COUNTRY OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH OF SPOUSE

CAUSE OF DEATH OF SPOUSE

DATE OF DEATH OF FATHER

NAME OF FATHER

DATE OF DEATH OF MOTHER

NAME OF MOTHER

DATE OF DEATH OF GRANDFATHER

NAME OF GRANDFATHER

DATE OF DEATH OF GRANDMOTHER

NAME OF GRANDMOTHER

DATE OF DEATH OF UNCLE

NAME OF UNCLE

DATE OF DEATH OF AUNT

NAME OF AUNT

DATE OF DEATH OF BROTHER

NAME OF BROTHER

DATE OF DEATH OF SISTER

NAME OF SISTER

DATE OF DEATH OF NEPHEW

NAME OF NEPHEW

DATE OF DEATH OF NIECE

NAME OF NIECE

DATE OF DEATH OF COUSIN

NAME OF COUSIN

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

DATE OF DEATH OF OTHER RELATIVE

NAME OF OTHER RELATIVE

BUREAU V.I.E

MAY 2 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3857 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03837

Reg. Dist. No. 62

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Caroline</u> <span style="float: right;">MARYLAND</span>   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>       |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Denton</u>   |  | c. LENGTH OF STAY IN 1b<br><u>50 yrs</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Denton</u>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  |   |  | d. STREET ADDRESS  |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>CARRIE</u> Middle <u>WRIGHT</u> Last <u>WRIGHT</u>   |  |   |  | <b>4. DATE OF DEATH</b><br>Month <u>APR</u> Day <u>28</u> Year <u>1956</u>   |  |  |  |
| 5. SEX <u>7</u>   |  | 6. COLOR OR RACE <u>N</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 8. DATE OF BIRTH<br><u>AUG (3) 1882</u>   |  | 9. AGE (In years last birthday)<br><u>73</u> yrs.   |  | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u><br>IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>                      |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 13. FATHER'S NAME <u>David Wisher</u>   |  |  |  |  |  |
| 14. MOTHER'S MAIDEN NAME <u>Effie Wilmer</u>  |  |   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)                                      |  |  |  |
| 16. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT <u>Roger Wright, Denton, Md</u> Address  |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br><u>450.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u><br>DUE TO (c)  |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |
| 20f. (City or town)   |  | (County)  |  | (State)  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Aaron D. George</u> M.D.  |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |  |
| EXAMINER'S NAME (Type) <u>A. Dawson, O. George</u>  |  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   | DATE SIGNED <u>4/30/56</u>   |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>May 1, 1956</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Bell Chapel</u>  |  |  |  |
| 22d. LOCATION (City, town, or county) <u>Denton, Md</u>   |  | (State)   |  |  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Mowbray, Denton</u>   |  |   | 24a. REC'D BY REGISTRAR <u>4/30/56</u>   |  |  |  |  |
| 24b. REGISTRAR'S SIGNATURE <u>Am L. O. George</u>   |  |   | DATE   |  |  |  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 3 1956

RECEIVED